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	B023016	A. BUILDING: _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE HAVEN VILLAGE	1701 RESEARCH PARK DRIVE LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of an initial survey with complaint investigation 83515 at the above named home plus facility on 1-29-15, 2-2-15, 2-3-15 and 2-4-15.	S 000		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, record review and interview for 1 (#900) of 3 sampled residents, the operator failed to ensure designated staff conducted a screening to determine each resident's functional capacity following a significant change in condition. Findings included: - Record review for resident #900 revealed admission on 11-4-14 with diagnoses Alzheimer's Dementia, Hypertension, Cardiovascular Accident Prophylaxis, Behaviors, Agitation, and Allergies. The Functional Capacity Screen (FCS) upon	S5085		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S5085	Continued From page 1	S5085		

admission dated 11-5-14 recorded resident required supervision with bathing, dressing and toileting; independent with transfers, walking/mobility and eating; and unable to perform management of medications and treatments. Occasionally incontinent of bladder. Cognition: impairment of short term and long term memory, memory/recall and decision-making. Problems identified included falls/unsteadiness, impaired decision-making and wandering. (The FCS lacked revision when the resident experienced a change in condition.)

The Negotiated Service Agreement (NSA) and Health Services Plan (HSP) upon admission dated 11-5-14 recorded services for supervision with bathing three times per week; Assistance with dressing; supervision of toileting and staff to administer medications. The Health Services Plan (HSP) lacked health services to address resident's current impaired mobility, impaired ability to feed self and risk for falls.

Observation and interview on 1-29-15 at 2:05 pm revealed certified staff G feeding resident a cheeseburger and french fries with a fork. Resident sitting with eyes closed chewing occasionally. Certified staff G providing frequent cueing and prompting to get resident to chew and swallow. Certified staff G stated resident will stop chewing and sometimes pocket food in his/her mouth.

Observation and interview on 1-29-15 at 3:13 pm revealed certified staff G and H toileting resident. Resident was sitting in a chair at bedside. Staff put gait belt on resident and instructed resident to stand with walker. Staff provided physical assistance and verbal cueing to help resident stand up. While ambulating with resident to the

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S5085	Continued From page 2 bathroom, observed that both staff pulled the resident along and resident had trouble controlling his/her feet, shuffled, knees bent and stooped over. After toileting, when staff attempted to ambulate resident back to his/her chair, resident became unable to bear weight and was assisted onto a shower chair until a wheelchair could be found. Certified staff G and H confirmed resident is definitely a two person transfer and resident had a fall a couple of weeks ago when he/she tried to get out of bed without assistance. Confidential interviews with staff confirmed resident #900 has had increased difficulty walking and has required two person physical assistance with transfers, ambulation and toileting since around the end of December or first of January. Further confirmed the resident has required a wheel chair at times due to inability to bear weight. Also stated resident used to feed self until around the first of January. Interview on 1-29-15 at 5:16 pm with licensed staff C confirmed the resident experienced a significant change in condition and the resident's functional capacity was not assessed to reflect the resident's need for physical assistance with toileting, transfers, walking/mobility and eating; and that resident requires use of a wheelchair at times. For resident #900, the operator failed to ensure the licensed nurse conducted a screening to determine the resident's functional capacity following a significant change in condition which resulted in the resident requiring physical assistance with toileting, transfers, walking/mobility and eating.	S5085		

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S5105	Continued From page 3	S5105		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 1 (#800) of 3 sampled residents, the operator failed to ensure the negotiated service agreement provided a description of the services the resident will receive for blood sugar monitoring. Findings included: - Record review for resident #800 revealed admission on 12-1-14 with diagnoses Hypertension, Dementia, Insulin Dependent Diabetes Mellitus, Gastroesophageal Reflux	S5105		

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S5105	Continued From page 4 Disorder, Debility, Edema and Chronic Pain. The Functional Capacity Screen dated 12-1-14 recorded resident unable to perform medication/treatment management. The Negotiated Service Agreement (NSA) dated 12-1-14 recorded facility to provide medication assistance. The NSA lacked a description of services diabetes management including who is responsible for performing blood sugar monitoring. Review of Medication Administration Record for January 2015 and physician's orders revealed: Accuchecks (blood sugar monitoring) three times a day before meals with entries initialed as done by certified staff F, H and I. Interview on 1-29-15 at 4:31 pm with licensed staff C confirmed the above certified medication aides are delegated to perform blood sugar monitoring. Further confirmed the NSA lacked documentation of who is responsible for performance of blood sugar monitoring. For resident #800, the operator failed to ensure the negotiated service agreement provided a description of the services the resident will receive for blood sugar monitoring.	S5105		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100;	S5116		

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S5116	Continued From page 5 (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, record review and interview for 1 (#900) of 3 sampled residents, the operator failed to ensure the review and revision of the negotiated service agreement following a significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #900 revealed admission on 11-4-14 with diagnoses Alzheimer's Dementia, Hypertension, Cardiovascular Accident Prophylaxis, Behaviors, Agitation, and Allergies. The Functional Capacity Screen (FCS) upon admission dated 11-5-14 recorded resident required supervision with bathing, dressing and toileting; independent with transfers, walking/mobility and eating; and unable to perform management of medications and treatments. Occasionally incontinent of bladder. Cognition: impairment of short term and long term memory, memory/recall and decision-making. Problems identified included falls/unsteadiness,	S5116		

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S5116	Continued From page 6	S5116		

impaired decision-making and wandering. (The FCS lacked revision when the resident experienced a change in condition.)

The Negotiated Service Agreement (NSA) and Health Services Plan (HSP) upon admission dated 11-5-14 recorded services for supervision with bathing three times per week; Assistance with dressing; supervision of toileting and staff to administer medications. The Health Services Plan (HSP) lacked health services to address resident's current impaired mobility, impaired ability to feed self and risk for falls.

Review of Nurses Notes revealed the following (no time documented on the entries):
11-18-14: "Staff reports resident complains of pain with weight bearing to right knee and hip. Right knee appears swollen - knee cap tender to touch ...no bruises or redness noted to knee. States it hurts to walk a little. Gait unsteady. Staff to assist for safety." Signed by licensed staff C.
11-29-14: "This nurse received call stated resident was found in floor in room beside bed - floor wet where resident had urinated on floor ..." Signed by licensed staff C.
11-30-14: "Spoke with physician, informed of resident being found in floor. Reported also resident sleeping continuously throughout day and night probably 20+ hours - will sleep through meals and refuse to wake up for medications." Signed by licensed staff C.
12-12-14: "No change in resident. Continues to sleep a lot - gait unsteady and complains of pain in right knee/hip." Signed by licensed staff C.
1-5-15: "Resident continues to have difficulty walking complains of pain right knee/hip." Signed by licensed staff C.
1-15-15: " Resident continues to sleep a lot - staff will keep out of room but sleeps in chair.

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S5116	Continued From page 7 Gait increasingly unsteady possible related to increased sleepiness or dizziness and complaint of pain to right knee/hip." Signed by licensed staff C. 1-29-15: "Staff may at times use wheelchair for when resident refuses/can't walk - will monitor closely - family, doctor informed and ok but staff to encourage to ambulate." Signed by licensed staff C. Observation and interview on 1-29-15 at 2:05 pm revealed certified staff G feeding resident a cheeseburger and french fries with a fork. Resident sitting with eyes closed chewing occasionally. Certified staff G providing frequent cueing and prompting to get resident to chew and swallow. Certified staff G stated resident will stop chewing and sometimes pocket food in his/her mouth. Observation and interview on 1-29-15 at 3:13 pm revealed certified staff G and H toileting resident. Resident was sitting in a chair at bedside. Staff put gait belt on resident and instructed resident to stand with walker. Staff provided physical assistance and verbal cueing to help resident stand up. While ambulating with resident to the bathroom observed that both staff pulled the resident along and resident had trouble controlling his/her feet, shuffled, knees bent and stooped over. After toileting, when staff attempted to ambulate resident back to his/her chair, resident became unable to bear weight and was assisted onto a shower chair until a wheelchair could be found. Certified staff G and H confirmed resident is definitely a two person transfer and resident had a fall a couple of weeks ago when he/she tried to get out of bed without assistance.	S5116		

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S5116	Continued From page 8 Confidential interviews with staff confirmed resident #900 has had increased difficulty walking and has required two person physical assistance with transfers, ambulation and toileting since around the end of December or first of January. Further confirmed the resident has required a wheel chair at times due to inability to bear weight. Also stated resident used to feed self until around the first of January. Interview on 1-29-15 at 5:16 pm with licensed staff C confirmed the resident needs a wheelchair and is a 2 person physical assist with transfers and ambulation. Confirmed the resident had a significant change in condition and the health services plan lacked revision to include interventions to address resident's decreased ability to feed self, appropriateness of diet, decreased mobility and fall risk. For resident #900, the operator failed to ensure the review and revision of the negotiated service agreement following a significant change in condition as defined in K.A.R. 26-39-100.	S5116		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, record review and interview for 1	S5171		

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S5171	Continued From page 9	S5171		

(#900) of 3 sampled residents, the operator failed to ensure all health care services shall be provided to the resident by qualified staff in accordance with acceptable standards of practice.

Findings included:

- Record review for resident #900 revealed admission on 11-4-14 with diagnoses Alzheimer's Dementia, Hypertension, Cardiovascular Accident Prophylaxis, Behaviors, Agitation, and Allergies.

The Functional Capacity Screen (FCS) upon admission dated 11-5-14 recorded resident required supervision with bathing, dressing and toileting; independent with transfers, walking/mobility and eating; and unable to perform management of medications and treatments. Occasionally incontinent of bladder. Cognition: impairment of short term and long term memory, memory/recall and decision-making. Problems identified included falls/unsteadiness, impaired decision-making and wandering.

The Negotiated Service Agreement (NSA) and Health Services Plan (HSP) upon admission dated 11-5-14 recorded services for supervision with bathing three times per week; Assistance with dressing; supervision of toileting and staff to administer medications.

The record lacked documentation of a fall on 1-18-15, assessment by a nurse following the incident and notification of family and physician.

Confidential interviews on 1-29-15 and 2-3-15 stated on 1-18-15 resident's personal alarm went off and resident was found on floor laying on left side around 12:30 pm in his/her room next to

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S5171	Continued From page 10 bed. After checking resident, staff called to notify licensed staff C and was instructed to take vital signs. Staff stated resident complained of back pain and remained in bed the rest of the day and confirmed no nurse came to assess him/her on the day of the incident or the next day after. Interview on 1-29-15 at 5:16 pm with licensed staff C confirmed there was an incident on 1-18-15 that was not documented and that physician and family were not notified. Further confirmed there was no follow up of incident and staff were not instructed to administer pain medication. For resident #900, the operator failed to ensure all health care services shall be provided to the resident by qualified staff in accordance with acceptable standards of practice after the resident experienced a fall resulting in back pain and decreased mobility.	S5171		
S5205 SS=F	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(a) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, and interview for 1 (#900) of 1	S5205		

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S5205	Continued From page 11	S5205		

residents requiring 2 staff for transfer, the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance to a secure location.

Findings included:

- Review of the resident roster revealed a total resident census of 7 residents. The roster identified 1 resident who could require 2 staff for transfers at times (resident #900).

- Record review for resident #900 revealed admission on 11-4-14 with diagnoses Alzheimer's Dementia, Hypertension, Cardiovascular Accident Prophylaxis, Behaviors, Agitation, and Allergies.

Observation and interview on 1-29-15 at 3:13 pm revealed certified staff G and H ambulating resident and from bathroom. Resident was sitting in a chair at bedside. Staff put gait belt on resident and instructed resident to stand with walker. Staff provided physical assistance and verbal cueing to help resident stand up. While ambulating with resident to the bathroom, observed that both staff pulled the resident along and resident had trouble controlling his/her feet; shuffled with bent knees and stooped over. After toileting, when staff attempted to ambulate resident back to his/her chair, resident became unable to bear weight and was assisted onto a shower chair until a wheelchair could be found. Certified staff G and H confirmed resident is definitely a two person transfer.

Confidential interviews with staff confirmed resident #900 has had increased difficulty walking and has required two person physical assistance with transfers, ambulation and toileting since

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S5205	Continued From page 12 around the end of December or first of January. Further confirmed the resident has required a wheel chair at times due to inability to bear weight. Interview on 1-29-15 at 5:16 pm with licensed staff C confirmed the resident needs a wheelchair and is a 2 person physical assist with transfers and ambulation at this time. Was not aware that resident required two staff to assist with transfers and ambulation/mobility stating he/she had seen resident ambulate as recently as "this past Friday ". Confirmed only one staff member had been scheduled every day from 8:00 pm until 8:00 am but now has scheduled another staff to work those hours to ensure there are 2 staff at all times. For resident #900, the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.	S5205		
S5215 SS=E	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and	S5215		

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S5215	Continued From page 13 (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(4) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for all residents, the operator failed to ensure disaster and emergency preparedness by ensuring quarterly review of the home's emergency management plan with residents and an emergency drill which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. Findings included: - Review of the home's emergency management plan revealed the plan lacked documentation of review with residents, employees and further lacked documentation of an emergency drill which included evacuation of the residents to a secure location. Interviews on 1-29-15 at 4:45 pm with administrative staff B and licensed staff C confirmed they had not performed an evacuation yet. Interview on 2-3-15 at 12:45 pm with licensed staff C confirmed the emergency preparedness review lacked documentation of review with the residents and employees.	S5215		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5215	Continued From page 14 For all residents, the operator failed to ensure disaster and emergency preparedness by ensuring quarterly review of the home's emergency management plan with residents and an emergency drill which shall be conducted at least annually with staff and residents.	S5215		
S5265 SS=D	26-42-205 (a) (1) Medication Self Administration Assessment (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(a)(1) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 1 (#800) of 1 sampled residents taking insulin, the operator failed to	S5265		

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S5265	Continued From page 15 ensure the licensed nurse performed an assessment to determine the resident's ability to safely inject insulin; and failed to ensure this assessment was completed initially before the resident began self-injection of insulin. Findings included: - Record review for resident #800 revealed admission on 12-1-14 with diagnoses Hypertension, Dementia, Insulin Dependent Diabetes Mellitus, Gastroesophageal Reflux Disorder, Debility, Edema and Chronic Pain. The Functional Capacity Screen dated 12-1-14 recorded resident unable to perform medication/treatment management. The Negotiated Service Agreement (NSA) dated 12-1-14 recorded facility to provide medication assistance. Review of Medication Administration Record for January 2015 and physician's orders revealed: Sliding Scale Novolog Flexpen for Glucose 150-200, 1 unit; 201-250, 2 units; 251-300, 3 units; 301-350, 4 units; over 351, 5 units. Lantus 25 units subcutaneously at bedtime. Observation and interview on 1-29-15 at 3:15 pm revealed resident alert and oriented to self and place watching television and crocheting. Stated, "the nurses here give me my insulin" and indicated it was administered in his/her arms. Observation of both shoulders (deltoid region) revealed small purple bruises: two on right upper arm and 1 on left upper arm. Interview on 1-29-15 at 5:25 pm with certified staff H stated "we do the blood sugar first and compare it to the sliding scale chart, dial it up on	S5265		

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S5265	Continued From page 16 the pen and hand it to him/her. If he/she refuses to self-inject, we notify the nurses and they come and give it." Further stated the resident usually gives it in his/her shoulders. Interviews on 2-3-15 at 10:50 and and 11:00 am with certified staff F and I both stated resident #800 self-injected the insulin in his/her stomach. Interview on 1-29-15 at 4:31 pm with licensed staff C confirmed the record lacked documentation of the resident's ability to safely inject insulin. For resident #800, the operator failed to ensure the licensed nurse performed an assessment to determine the resident's ability to safely inject insulin; and failed to ensure this assessment was completed initially before the resident began self-injection of insulin.	S5265		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S5300		

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S5300	Continued From page 17 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 1 (#900) of 3 sampled residents. The operator failed to ensure all medications were administered to the resident in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for resident #900 revealed admission on 11-4-14 with diagnoses Alzheimer's Dementia, Hypertension, Cardiovascular Accident Prophylaxis, Behaviors, Agitation, and Allergies. The Functional Capacity Screen (FCS) upon admission dated 11-5-14 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement (NSA) and Health Services Plan (HSP) upon admission dated 11-5-14 recorded services for staff to administer medications. Medication Administration Record and Physician's order (effective 11-4-14): Tylenol 500 mg (milligrams) tablet. Give 1 to 1 tablets by mouth every 6 hours as needed for pain or temp. Review of Nurses Notes revealed the following (no time documented on the entries): 11-4-14: "...Right knee slightly swollen and	S5300		

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S5300	Continued From page 18	S5300		

complains of pain to right knee/hip with ambulation." Signed by licensed staff C. The record lacked documentation of administration of Tylenol 500 mg.
11-18-14: " Staff reports resident complains of pain with weight bearing to right knee and hip. Right knee appears swollen - knee cap tender to touch ...no bruises or redness noted to knee. States it hurts to walk a little. Gait unsteady. Staff to assist for safety. " Signed by licensed staff C. The record lacked documentation of administration of Tylenol 500 mg.
11-19-14: "Spoke with family regarding resident complaining of right knee pain. Family states has had issues with this for a while, Arthritis. Will monitor closely." Signed by licensed staff C. The record lacked documentation of administration of Tylenol 500 mg or instructions to staff to administer for pain control.
12-12-14: " No change in resident. Continues to sleep a lot - gait unsteady and complains of pain in right knee/hip. " Signed by licensed staff C. The record lacked documentation of administration of Tylenol 500 mg.
12-17-14: "Resident's gait unsteady and complained of pain to right knee/hip." Signed by licensed staff C. The record lacked documentation of administration of Tylenol 500 mg.
1-5-15: " Resident continues to have difficulty walking complains of pain right knee/hip. " Signed by licensed staff C. The record lacked documentation of administration of Tylenol 500 mg.
1-15-15: " Gait increasingly unsteady possible related to increased sleepiness or dizziness and complaint of pain to right knee/hip. " Signed by licensed staff C. The record lacked documentation of administration of Tylenol 500 mg.

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S5300	Continued From page 19 1-20-15: "Family member here - discussed resident's complaints of increased pain in knee/hip - difficulty walking." Signed by licensed staff C. The record lacked documentation of administration of Tylenol 500 mg. 1-28-15: "Spoke with physician - order received for x-ray right knee/hip related to pain and refusing to walk." Signed by licensed staff C. The record lacked documentation of administration of Tylenol 500 mg. 1-29-15: " Results of x-ray...no acute fracture or dislocation - Degenerative Osteoarthritis... " Signed by licensed staff C. Interview on 2-3-15 at 12:35 pm with licensed staff C confirmed he/she was aware resident had pain in right knee/hip and resident did not have an order for a routine pain medication to manage his/her right knee/hip pain. Further confirmed the certified staff had not been instructed to administer Tylenol PRN (as needed) as ordered by the physician in accordance with professional standards of practice. For resident #900, the operator failed to ensure all medications were administered to the resident in accordance with the medical care provider's written order and professional standards of practice when the resident experienced ongoing pain in right knee/hip and licensed staff failed to instruct the certified staff to administer pain medication as ordered by the resident's physician.	S5300		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in	S5315		

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S5315	Continued From page 20 accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(1) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation and interview, the licensed nurses and medication aides failed to ensure all	S5315		

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S5315	Continued From page 21 medications are securely and properly stored in accordance with the manufacturer's recommendations. Findings included: - Observation on 1-29-15 at 11:55 am revealed the following: 1 vial of tuberculin skin testing solution filled on 11-14-14 open and half full. The vial lacked documentation of date when it was opened. Confirmed by licensed staff C and removed to be discarded. Lantus and Novolog insulin pens in the refrigerator. 1 open and in-use Novolog insulin pen 100 units/milliliter, for resident #800. Lacked documentation of date when opened. 1 open and in-use Lantus Solostar insulin pen 100 units/milliliter, for resident #800. Lacked documentation of date when opened. Interviews on 1-29-15 at 11:55 am and 2:50 pm with licensed staff C and certified staff H confirmed in-use insulin pens were always stored in the refrigerator. Stated they did not know the pens were supposed to be stored at room temperature after opening. Licensed nurses and medication aides failed to ensure all medications and biologicals were properly stored in accordance with the manufacturer's recommendations.	S5315		
S5328 SS=F	26-42-205 (l) (3) Medication Regimen Review Documentation (3) The administrator or operator, or the	S5328		

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S5328	Continued From page 22 designee, shall ensure that the medication regimen review is kept in each resident ' s clinical record. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l)(3) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 2 (#800, #900) of 2 sampled residents with medication regimen reviews and potentially affecting all residents, the operator failed to ensure that the medication regimen review is kept in each resident's clinical record. Findings included: - Record review for resident #800 revealed admission on 12-1-14 with diagnoses Hypertension, Dementia, Insulin Dependent Diabetes Mellitus, Gastroesophageal Reflux Disorder, Debility, Edema and Chronic Pain. The Functional Capacity Screen dated 12-1-14 recorded resident unable to perform medication/treatment management. The Negotiated Service Agreement and Health Services Plan dated 12-1-14 recorded services for facility staff to administer medications. The record lacked documentation of a medication management review. - Record review for resident #900 revealed admission on 11-4-14 with diagnoses Alzheimer's Dementia, Hypertension, Cardiovascular Accident Prophylaxis, Behaviors, Agitation, and Allergies.	S5328		

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S5328	Continued From page 23 The Functional Capacity Screen dated 11-5-14 recorded resident unable to perform management of medications/treatments. The Negotiated Service Agreement and Health Services Plan dated 11-5-14 recorded services for staff staff to administer medications. The record lacked documentation of a medication regimen review. Interview on 1-29-15 at 2:45 pm with licensed staff C stated consulting pharmacist performed a medication regiment review on 12-18-14 and about 2 weeks later provided a written summary report. (Licensed staff C provided an undated medication regimen review summary report which stated "The drug regimen review has been completed for each resident for the month of December 2014; and indicated 4 total comments/recommendation noted. The summary lacked documentation specific to any residents.)Confirmed all resident records lacked documentation of the medication regimen review. For residents #800 and #900 and potentially affecting all residents, the operator failed to ensure that the medication regimen review is kept in each resident's clinical record.	S5328		